DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/16/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185244	A. BUILDING _____ B. WING _____	C 02/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-STANFORD	105 HARMON HEIGHTS STANFORD, KY 40484

RECEIVED
MAR 18 2011
Division of Health Care
Southern Enforcement Branch

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey (KY15904) was conducted on February 8-9, 2011. The allegation was substantiated. Deficient practice was identified with the highest scope and severity at "D" level.	F 000	Disclaimer: Preparation and submission of this plan of correction does not constitute an admission of agreement of any kind by the facility or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this time frame should in no way be considered or constructed as agreement with the allegations of non-compliance or admissions by the facility. The plan of correction is submitted as the facility's credible allegation of compliance.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure one of four sampled residents (resident #1) who was unable to carry out activities of daily living received adequate care and services to maintain optimal hygiene. The findings include: A review of resident #1's closed record revealed the resident was admitted to the facility on July 22, 2010, with diagnoses including Deforming Rheumatoid Arthritis, Dysphagia, Bedfast, Recurrent Aspiration Pneumonia, Dementia, and Gastrostomy Tube Placement. Resident #1 was transferred and admitted to the hospital on October 11, 2010, and subsequently expired on October 12, 2010. A review of resident #1's Minimum Data Set (MDS) assessment dated August 4, 2010,	F 312		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 3-18-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 312	Continued From page 1 revealed the resident was moderately cognitively impaired, sometimes understood/understands, and was totally dependent for physical functioning and activities of daily living (ADL) performance, including bathing/personal hygiene. Resident #1 was assessed to not have any behavioral symptoms or be resistive to care. Additionally, interviews conducted on February 8, 2011, at 5:07 p.m. with CNA #1, 5:15 p.m. with CNA #2, and on February 9, 2011, at 9:35 a.m. with CNA #3, 9:02 a.m. with Licensed Practical Nurse (LPN) #1, 9:24 a.m. with LPN #2, 9:30 a.m. with LPN #3, and 9:50 a.m. with Registered Nurse (RN) #1, revealed resident #1 was not resistive to care including baths/showers. A review of resident #1's ADL Flow Sheet Logs from July 22, 2010 until October 11, 2010 (eleven weeks and four days), revealed resident #1 received only four showers and one bath for the time period, receiving only partial baths on days between the showers/bath. An interview was conducted with the MDS Coordinator on February 8, 2011, at 4:45 p.m. The MDS Coordinator stated that assessing the amount of assistance required by a resident to complete their personal hygiene was the only assessment conducted by him/her, and that he/she did not participate in the decision-making process of how often a resident would receive baths/showers. Interviews were conducted on February 8, 2011, at 4:47 p.m., and February 9, 2011, at 1:15 p.m., with the Assistant Director of Nursing (ADON). The ADON stated the facility did not have a written policy/procedure regarding frequency of resident baths but explained the facility protocol	F 312	1. Resident #1 is deceased. 2. All residents have the potential to be affected by this deficient practice. 3. Residents who are unable to carry out activities of daily living will receive the necessary services to maintain good personal hygiene. Residents will be assessed for preferences and hygiene needs upon admission and with the RAI process. Nursing staff were educated by the Director of Education Services on residents bathing preferences and schedules which concluded on 2-22-11. The charge nurse for each wing will monitor residents and care tracker documentation to ensure optimal hygiene, i.e. odor free, clean, provided. 4. The Director of Clinical Services will monitor residents and review documentation to ensure residents received adequate care and services to maintain personal hygiene, i.e. odor free, clean, neatly groomed. The DNS will conduct a weekly review. The results of the review will be presented during the Quarterly Quality Assurance meeting which includes the medical director.	3-18-2011

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F 312	Continued From page 2 was for each resident to receive at a minimum one bath/shower weekly, with more frequent baths/showers if requested by the resident/resident's family or if assessed to need more frequent bathing/showering. The ADON stated the facility "explains" this procedure to the resident/family upon admission, and it would be the responsibility of the resident/family to notify the facility if more frequent bathing was desired. Although the ADON indicated in the interviews that a resident may receive more frequent baths/showers if assessed to need them, the ADON was unable to describe any system in place to assess residents' individualized bath/shower needs. The ADON stated, "No, we do not go around and ask them" (residents) if one shower a week met their needs, or question residents to ensure the weekly shower/bath was actually being provided as required by the protocol. Additionally, the ADON was unable to explain why resident #1 had not received at a minimum the required weekly bath/shower, stating he/she had been unaware the resident had received only four showers and one bath since being admitted to the facility until brought to his/her attention by the surveyor.	F 312		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 185244	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 2/9/2011
NAME OF PROVIDER OR SUPPLIER: GOLDEN LIVINGCENTER-STANFORD	STREET ADDRESS, CITY, STATE, ZIP CODE: 105 HARMON HEIGHTS STANFORD, KY		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 515	483.75(I)(2) RETENTION OF RESIDENT CLINICAL RECORDS

Clinical records must be retained for the period of time required by state law; or five years from the date of discharge when there is no requirement in State law; or, for a minor, three years after a resident reaches legal age under State law.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review it was determined the facility failed to retain clinical records as required for one of four sampled residents.

The findings include:

An abbreviated standard survey was initiated at the facility on February 8, 2011. A request was made to the Administrator on February 8, 2011, at 9:30 a.m., to review resident #1's closed medical record.

An interview with the Administrator on February 8, 2011, at 10:05 a.m., revealed resident #1's medical record had not been retained in the facility and could not be provided for review at that time. The Administrator stated that upon attempting to obtain the medical record a handwritten note was found stating, "I (a representative of an attorney's office) hereby take custody of the original medical (one volume) and business (one volume) files for [resident #1]." The correspondence was signed and dated November 30, 2010.

A request was made to the Administrator on February 8, 2011, at 10:30 a.m., for the facility to attempt to obtain resident #1's medical record in order to complete the abbreviated survey. Further interview with the Administrator on February 8, 2011, at 10:55 a.m., revealed the legal office where resident #1's medical record was located (approximately 95 miles away from the facility) had been contacted, and a courier would have to bring the record to the facility.